PRIOR AUTHORIZATION FAX-FORM ---- KENTUCKY MEDICAID HOME HEALTH SERVICES PROGRAM

Date Fax-Form Completed: ___/___/_____

➢ TYPE OR CLEARLY PRINT IN DARK INK ONLY. ILLEGIBLE & INCOMPLETE FORMS WILL BE RETURNED UNPROCESSED.

☐ **Supply ONLY** ☐ **New Patient** ☐ **Re-Authorization** ☐ **Modification**

Start of Care Date (from 485, if available) _____ Date Most Recent 485 Completed: _____

MAID#: _____(10 digits) ☐ Check if patient has been **discharged** & provide date of discharge _____

Demographic Data:

☐ Check if demographic data has changed

Patient Information: _____ Gender: M☐ F☐
Last First MI (check one)

Address: _____

Home Telephone: (____) _____ Date of Birth: __/__/_____ County of Residence: _____

Agency Information: Agency Name: _____

Address: _____

Requestor Name: _____ Contact (if different) _____

Telephone #: (____) _____ Fax #: (____) _____ Provider #: _____(8 digits)

Clinical Information: Primary Dx(s) [ICD-9-CM code & descriptions]: _____

Secondary Dx(s) [ICD-9-CM code & descriptions]: _____

_____

Is patient restricted to home due to medical conditions?	Is there a willing and reliable caregiver?
☐Yes ☐No …If no, please explain need for home health services in lieu of outpatient services: _____	☐Yes ☐No … If no, give reason why unwilling and unreliable: _____

Update: _____

_____

_____

WOUND LOCATION(S)	MEASUREMENTS:		
	Length	Depth	Width
•			
•			

Services Requested (Revenue Code)	# Visits Requested	Start Date	End Date	Services Requested (Revenue Code)	# Visits Requested	Start Date	End Date

Enterals Requested (Revenue Code 279)	# Items	Recipient's Height	Recipient's Weight

Supplies Requested (Revenue Code 270)	# Items	Supplies Requested (Revenue Code 270)	# Items

FAX COMPLETED FAX-FORM TO:
National Health Services (NHS)
At 1-800-664-5749

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IN LIEU OF FAX:
Call NHS
At 1-800-664-5725